STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 00 B. WING	04/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN HEALTH AND REHABILITATION CENTER	3400 STOCKER DR EVANSVILLE, IN47720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00088724. Complaint IN00088724 -Substantiated, Federal/State deficiencies are cited at F272, F279, F282, F323, and F514. Unrelated deficiencies are cited Survey dates: April 13 and 14, 2011 Facility number: 000442 Provider number: 155621 AIM number: 100266510 Survey team: Anne Marie Crays, RN Census bed type: SNF: 41 SNF/NF: 62 Total: 103	F0000	Pine Haven POC By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective May 14, 2011 to the complaint survey conducted on April 14, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Census payor type: Medicare: 21 Medicaid: 54 Other: 28 Total: 103 Sample: 6 These deficiencies also reflect state findings cited in accordance with 42 CFR Part 483 Subpart B and 410 IAC 16.2. Quality review completed on April 20, 2011 by Bev Faulkner, RN			

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F0225 SS=A	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			

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	Based on interview and record review, the facility failed to report an allegation of misappropriation of property to the Indiana State Department of Health [ISDH] within the required time frame, for 1 of 6 residents reviewed for abuse, in a sample of 6. Resident D Findings include: On 4/14/11 at 9:00 A.M., the Administrator provided a "Fax/Incident Report," sent to the ISDH. The report included, "...Incident Date 1/23/11...It was reported to me on 1/15/11 that a resident on [unit name] reported that her quarters were missing from her room. She stated that it was [approximately] $40.00 worth of quarters...." On 4/14/11 at 11:50 A.M., during interview with the Administrator, she indicated she did not immediately report the resident's	F0225	**F225** **It is the practice of this facility to assure that the misappropriation of resident funds is reported to the appropriate agencies on a timely basis as required by regulation.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** The misappropriation of Resident #D's funds was reported - even though it was reported untimely. There have been no further issues related to this resident regarding misappropriation of funds. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected by the deficient practice. The Interim Administrator has been re-inserviced regarding this policy to assure a thorough understanding of the regulation. The Administrator involved in the unusual occurrence reporting related to this incident is no longer employed at the facility. ***The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:*** The policy related to reporting of abuse or misappropriation of resident funds has been re-inserviced to	05/14/2011

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	complaint of missing money to the ISDH. The Administrator indicated she waited until the investigation was completed before she reported the incident. 3.1-28(c)		assure a thorough understanding of the regulation including the reporting of unusual occurrences in a timely manner. All staff having a role in the implementation of this policy have been in-serviced. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to review prompt adherence to the abuse policy, including notification of the appropriate state agencies. It is the Administrator's responsibility to assure that the appropriate agencies are notified of any allegations in a timely manner. The Administrator, or designee, will complete this audit monthly x3, then quarterly x3. The Quality Assurance Committee will review the results of the audit at the scheduled meeting following the completion of the audit with recommendations as needed. ***The date the systemic changes will be completed:*** May 14, 2011	
F0226 SS=A	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record	F0226	**It is the practice of this facility to**	05/14/2011

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	review, the facility failed to implement their policy of reporting an allegation of misappropriation of property to the Indiana State Department of Health [ISDH] within the designated time frames, for 1 of 6 residents reviewed for abuse, in a sample of 6. Resident D Findings include: 1. On 4/13/11 at 10:00 A.M., the Administrator provided the current facility policy on "Abuse Prohibition," dated 2/11. The policy included: "Allegations/suspicions/reports of abuse will be investigated immediately to ensure the safety and well being of the resident. 'Abuse' means the willful infliction of injury, unreasonable confinement...includes deprivation of goods or services that are necessary to maintain their well being...Financial exploitation is defined as an improper course of conduct with or without informed consent of the older adult that		**assure that the Administrator is notified immediately related to allegation of abuse, neglect, or misappropriation of property. The Administrator is then responsible for notifying the appropriate agencies as required in a timely manner, per the facility policy and the regulation.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #D has had no further issues related to misappropriation of funds. Please refer to systemic changes related to policy and reporting mechanisms to the appropriate state agencies. ***Other residents that have the potential to be affected have been identified by:*** Potentially, all residents could be affected, and therefore the current policy has been re-inserviced to assure a thorough understanding of the regulation. ***The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:*** The policy related to reporting of abuse or misappropriation of resident funds has been re-inserviced to assure a thorough understanding of the regulation, including the	

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	results in monetary, personal or other benefit, gain or profit for the proprietor or monetary or personal loss for the older adult...Reported instances of any of the above situations will be investigated immediately and reported to the appropriate authorities and agencies...." 2. On 4/14/11 at 9:00 A.M., the Administrator provided a "Fax/Incident Report," which was sent to the ISDH. The report included, "...Incident Date 1/23/11...It was reported to me on 1/15/11 that a resident on [unit name] reported that her quarters were missing from her room. She stated that it was [approximately] $40.00 worth of quarters...." On 4/14/11 at 11:50 A.M., during interview with the Administrator, she indicated she did not immediately report the resident's complaint of missing money to the ISDH. The Administrator indicated she waited until the investigation		reporting of unusual occurrences in a timely manner. All staff having a role in the implementation of this policy have been in-serviced. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to review reportable events to assure that they are reported timely in accordance with the facility policy and the regulation. It is the Administrator's responsibility to assure that the appropriate agencies are notified of any allegations in a timely manner. The Administrator, or designee, will complete this audit monthly x3, then quarterly x3. The Quality Assurance Committee will review the results of the audit at the scheduled meeting following the completion of the audit with recommendations as needed. ***The date the systemic changes will be completed:*** May 14, 2011	

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	was completed before she reported the incident. 3.1-28(a)			

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on observation, record review, and interview, the facility failed to ensure thorough and comprehensive assessment was completed in regards to prevention of falls, in that investigations into the root cause of the falls was not completed, for 3 of 3 residents	F0272	**Iti is tihe practice ofi Pine Haven Healtih and Rehabilitiation Centier tio assure tihati residentis are assessed properly relatied tio fiall risk and tihati an investigation is implementied relatied tio tihe fiall as tio tihe possible cause so tihati appropriatie intierventions can be implementied tio assisti witih tihe prevention ofi reoccurrence.** ***The correcton acton taken fior***	05/04/2011

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	reviewed for falls, in a sample of 6. Residents A, B, and C Findings include: 1. On 4/14/11 at 9:30 A.M., the facility compliance nurse provided the current facility policy on "Falls Prevention," dated 9/08. The policy included: "...To ensure that residents are safe and that appropriate preventive measures are initiated to minimize injuries related to falls. Procedure, If a fall occurs, the Falls Checklist will be initiated with all areas completed before the end of the shift the incident occurred...Nursing staff will document on the resident chart a thorough accounting of the incident as outlined in the Falls Checklist. Fall Preventive Measures...Motion Alarms (Bed/Chair)...Motion Sensors, Smart Floor Mat Alarm...Self-Releasing Alarm Belts, Restraints...All preventive measures must correlate with the resident's cognition level."		***those residents fiound to be afiected by the deficient practce include :*** Residentts#A and #C have been reassessed relatted tto flall risk and have been reviewed by tthe IDT tto assure tthatt appropriatte intterventtons are in place tto assistt witth tthe preventton ofl flalls Residentt#B, as identtfled in tthe 2567, no longer resides att tthe flacilitty ***Other residents that have the potental to be afiected have been identfied by :*** All residentts have been assessed relatted tto flall riskBased on tthe assessmentt intterventtons have been implementted tto assistt witth tthe preventton ofl flalls ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** The IDT Committee will begin reviewing any residentt who has experienced a flall tto assure tthatt based on tthe assessmentt ofl tthe possible cause ofl tthe flall appropriatte intterventtons are implementted tto assistt witth tthe preventton ofl reoccurrence ofl flalls The nursing sttafl has been in-serviced relatted tto flall preventton and tthe inittatton ofl tthe investtgatton flor immediatte intterventton. ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:***	

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	2. On 4/13/11 at 2:00 P.M., Unit Manager # 1 provided C.N.A. assignment sheets for her unit. The assignment sheets indicated that 23 residents resided on that unit. Seventeen (17) of those 23 residents had some type of fall prevention alarm to alert staff of unassisted rising. On 4/14/11 at 10:00 A.M., during interview with the compliance nurse, she indicated that her responsibility was to validate that "everything regarding a fall was documented properly, including updating the care plan." The compliance nurse indicated there was not "really an investigation on why a fall occurs," and that the usual intervention following a fall would be to add an alarm. 3. On 4/13/11 at 9:10 A.M., during the initial tour, Unit Manager # 1 indicated Resident A had fallen the previous night, and was not interviewable. Unit Manager # 1		A Perflormance Improvementt Tool has been inittatted tthatt will be uttlized tto review residentts tthatt are considered “att risk flor flalls” or have had an acttual flall tto assure tthatt intterventtons are in place tto preventt flalls and tthatt ifl a flall occurred tthatt an investtgatton in inittatted tto assure tthatt appropriatte intterventtons are implementted tto assistt witth tthe preventton ofl flutture flalls This ttool will randomly review 5 residentts The Directtor ofl Nursingor designee, will complette tthis ttool weeklyx3x monttthly x3, tthen quartterly x1. Any areas identtfled via tthe auditt will be immediattely correctted The Qualitty Assurance Committee will review tthe ttool att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed ***The date the systemic changes will be completed:*** 5-14-11	

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	indicated Resident A required a sensor pad alarm to her wheelchair and bed. Unit Manager # 1 indicated a tabs alarm was added to the wheelchair following the fall the previous night. The clinical record of Resident A was reviewed on 4/13/11 at 10:40 A.M. Diagnoses included, but were not limited to, Dementia. A Minimum Data Set [MDS] assessment, dated 1/17/11, indicated the resident scored a 9 out of 15 on a cognitive assessment, required limited assistance of 1 staff for transfer and ambulation, and had not fallen since the previous assessment. A test for "Balance during transitions and walking" indicated "Not steady, only able to stabilize with human assistance" while moving from seated to standing position, walking, and surface-to-surface transfer. A "Fall Risk" assessment, dated			

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	1/19/11, indicated Resident A had intermittent confusion, had 1-2 falls in the previous 3 months, had a balance problem while standing, required the use of an assistive device, and had a total score of 12. The assessment indicated, "Total score of 10 or above represents HIGH RISK" for falls. Nurse's Notes included the following notations: 4/12/11 at 10:00 P.M.: "Staff reports res [resident] yelling out 'nurse.' Upon entering res bathroom noted resident sitting on bottom of floor. W/C breaks [sic] locked. Res assessed for injury, none apparent...Res assisted off floor [with] extensive assist x [two] staff [and] gait belt...Res. placed to bed, alarms on et [and] functioning, call light within reach. TABS alarm added to res. w/c for preventative nursing measure related to decreased safety awareness." 4/13/11 at 1:00 A.M.: "Resident			

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	[up] getting in chair. Resident shut off bed alarm [before] getting out of bed. Instructed resident to leave alarms alone et call for help before getting up." On 4/14/11 at 9:00 A.M., the compliance nurse provided an "Incident/Accident Report," dated 4/12/11. The report included, "...Noted res on floor...[no] apparent injury, refer to nurses note...Additional comments and/or steps to prevent recurrence: tabs alarm to w/c." The compliance nurse indicated at that time that she was unaware of the reason the resident fell. 4. On 4/13/11 at 9:10 A.M., during the initial tour, the compliance nurse indicated Resident C had a diagnosis of Alzheimer's Disease, had a history of several falls, and utilized alarms. On 4/13/11 at 11:30 A.M., Resident C was observed sitting in a wheelchair in a lounge, asleep. A			

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	self release seatbelt alarm was observed on the resident. No staff were observed interacting with the resident. The clinical record of Resident C was reviewed on 4/13/11 at 11:45 A.M. Diagnoses included, but were not limited to, Alzheimer's Disease and Parkinson's Disease. A Minimum Data Set [MDS] assessment, dated 2/8/11, indicated Resident C had a short-term and long-term memory problem, was moderately impaired in cognitive skills for daily decision-making, required extensive assistance of two+ staff for transfer and bed mobility, and did not ambulate. A test for "Balance during transitions and walking" indicated "Not steady, only able to stabilize with human assistance" while moving from seated to standing position, moving on and off toilet, and surface-to-surface transfer. The MDS assessment indicated the resident had not fallen since the			

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	previous assessment. Nurses Notes included the following notations: 2/15/11 at 5:30 P.M.: "CNA approached Resident room et heard alarm sounding. Resident found in bathroom floor on [left] side...When resident asked what happened she stated 'was going to bathroom.' Resident toileted after writer evaluated." 2/15/11 at 5:45 P.M.: "[Physician] update on incident. Received new orders for UA, C/S [urinalysis, culture and sensitivity]. Also received orders for self releasing seat belt...." A "Falls Care Plan," initially dated 6/10, indicated a problem of "History of falls...Contributing factors, Alzheimer's Diagnosis, Forgets to ask for assistance...Generalized weakness..." The approaches indicated, "...Encourage to stay			

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	155621	A. BUILDING 00 B. WING	04/14/2011

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	seated or wait for assistance before transferring after meals...Is at risk for falls; will use the following preventive measure: Sensor pad to bed/recliner...12/7/10 tabs alarm to w/c, 2/15/11 Self releasing seat belt while in w/c." On 4/14/11 at 10:00 A.M., during interview with the compliance nurse, she indicated there was not a process in which the cause of the fall was assessed. 5. The closed clinical record of Resident B was reviewed on 4/13/11 at 1:20 P.M. Resident B was admitted to the facility on 3/19/11 with diagnoses including, but not limited to, Aftercare following surgery/digestive system. An admission care plan, undated, indicated: "Falls/Safety Risk/Elopement Risk. Goal: Resident will remain free of injuries and falls. Keep call bell in reach. Enc. use of call light. Instruct resident on safety			

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	measures...Mobility alarm SPA [sensor pad alarm] bed [and] chair...." Nurses Notes included the following notations: 3/25/11 at 3:00 A.M.: "Res remains delusional @ this time D/T [due to] res thinks her family is here et this us a hotel...thinks that nephew was in the bed next to her...." 3/25/11 at 11:00 A.M.: "Alert [with] some confusion...needs extensive assist [with] ADL's [activities of daily living]...." 3/25/11 at 3:30 P.M.: "Res spa [sensor pad alarm] heard sounding, CNA went to resident's room, resident found lying on back on floor in front of closet. Denies pain, bruise noted to lateral left forehead...assisted to w/c [with] assist x 3...." 3/25/11 at 3:45 P.M.: "Prevantive [sic] to prevent recurrent fall -			

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	self-release seat belt...." On 4/13/11 at 2:15 P.M., during interview with the compliance nurse, she indicated she would not have considered Resident B interviewable. She indicated Resident B had attempted unassisted ambulation earlier on 3/25/11, "probably around 2:00 P.M.," and a sensor alarm was placed on the resident's bed and wheelchair. The compliance nurse indicated she did not know why documentation regarding the attempt at unassisted ambulation was not in the clinical record, and did not know why the resident attempted unassisted ambulation. The compliance nurse indicated there was not a process to determine why the resident had attempted to self-ambulate, and why the resident had fallen. This federal tag relates to Complaint IN00088724. 3.1-31(a)			

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	3.1-31(e)			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review, and interview, the facility failed to develop and revise care plans to ensure individualized interventions were implemented for fall prevention, for 3 of 3 residents reviewed for falls, in a sample of 6.	F0279	**Iti is tihe practice ofi tihis fiacilitiy tio assure tihati tihe residentis' care plans are developed and address tihe needs identified by tihe comprehensive assessmenti** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** Residentts#A and #C have had care	05/14/2011

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	Residents A, B, and C Findings include: 1. On 4/14/11 at 9:30 A.M., the facility compliance nurse provided the current facility policy on "Falls Prevention," dated 9/08. The policy included: "...To ensure that residents are safe and that appropriate preventive measures are initiated to minimize injuries related to falls. ... Fall Preventive Measures...Motion Alarms (Bed/Chair)...Motion Sensors, Smart Floor Mat Alarm...Self-Releasing Alarm Belts, Restraints...All preventive measures must be added to the Falls Care Plan and dated...All preventive measures must correlate with the resident's cognition level." 2. On 4/13/11 at 2:00 P.M., Unit Manager # 1 provided C.N.A. assignment sheets for her unit. The assignment sheets indicated that 23 residents resided on that unit. 17 of those 23 residents had some type of		plan reviewed tto assure tthatt tthe plan ofl care accurattely reflectts tthe appropriatte intterventtons being uttlized relatted tto tthe preventton ofl flalls Residentt B no longer resides in tthe flacilitty ***Other residents that have the potental to be afiected have been identfied by :*** All residentts have been reviewed tto assure tthatt tthe plan ofl care addresses perttnentt inflormatton relatted tto flall preventton based on tthe assessmentt ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** The intterdisciplinary tteam is reviewing all flall risk assessmentts tto assure tthatt perttnentt areas on tthe comprehensive assessmentt are identtfled as partt ofl tthe plan ofl care An in-service has been conductted flor tthe nurses tto assure tthatt tthere is a tthorough understtanding relatted tto tthe issues identtfled on tthe assessmentt being addressed on tthe plan ofl care flor tthe residentt As partt ofl tthe systtem changet the Intterdisciplinary tteam will review all flalls assure tthatt an investtgatton was completted and assure tthatt tthe care plan has been updatted tto reflectt appropriatte intterventtons based on tthe possible cause ofl tthe flall ***The correctve acton taken to monitor perfiormance to assure compliance through quality***	

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	fall prevention alarm, to alert staff of unassisted rising. On 4/14/11 at 10:00 A.M., during interview with the compliance nurse, she indicated that her responsibility was to validate that "everything regarding a fall was documented properly, including updating the care plan." The compliance nurse indicated there was not "really an investigation on why a fall occurs," and that the usual intervention following a fall would be to add an alarm. 3. On 4/13/11 at 9:10 A.M., during the initial tour, Unit Manager # 1 indicated Resident A had fallen the previous night, and was not interviewable. Unit Manager # 1 indicated Resident A required a sensor pad alarm to her wheelchair and bed. Unit Manager # 1 indicated a tabs alarm was added to the wheelchair following the fall the previous night. The clinical record of Resident A		***assurance is:*** A Perflormance Improvementt Tool has been inittatted tthatt will be uttlized tto randomly review 5 residentts relatted tto tthe comprehensive assessmentt in correlatton witth tthe plan ofl care tto assure tthatt perttnentt inflormatton is identtfled on tthe plan ofl care based on tthe assessmentt The Directtor ofl Nursing, or designee, will complette tthis ttool weekly x 3, montthly x 3, tthen quartterly x 3. Any areas identtfled via tthe auditt will be immediattely correctted The Qualitty Assurance Committee will review tthe ttool att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed. ***The date the systemic changes will be completed:*** 5-14-11	

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	was reviewed on 4/13/11 at 10:40 A.M. Diagnoses included, but were not limited to, Dementia. A Minimum Data Set [MDS] assessment, dated 1/17/11, indicated the resident scored a 9 out of 15 on a cognitive assessment, required limited assistance of 1 staff for transfer and ambulation, and had not fallen since the previous assessment. A test for "Balance during transitions and walking" indicated "Not steady, only able to stabilize with human assistance" while moving from seated to standing position, walking, and surface-to-surface transfer. A "Fall Risk" assessment, dated 1/19/11, indicated Resident A had intermittent confusion, had 1-2 falls in the previous 3 months, had a balance problem while standing, required the use of an assistive device, and had a total score of 12. The assessment indicated, "Total score of 10 or above represents			

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	HIGH RISK" for falls. Nurse's Notes included the following notations: 4/12/11 at 10:00 P.M.: "Staff reports res [resident] yelling out 'nurse.' Upon entering res bathroom noted resident sitting on bottom of floor. W/C breaks [sic] locked. Res assessed for injury, none apparent...Res assisted off floor [with] extensive assist x [two] staff [and] gait belt...Res. placed to bed, alarms on et [and] functioning, call light within reach. TABS alarm added to res. w/c for preventative nursing measure related to decreased safety awareness." 4/13/11 at 1:00 A.M.: "Resident [up] getting in chair. Resident shut off bed alarm [before] getting out of bed. Instructed resident to leave alarms alone et call for help before getting up." A "Falls Care Plan," initially dated 10/31/10, indicated a problem of			

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	"History of falls...Contributing factors, Dementia, Arthritis...Use of w/c...Refusal of assistance, Refusal to use assistive devices." The approaches indicated, "Encourage to stay seated or wait for assistance before transferring after meals. Ensure frequently used items are within reach: Call system; Light cord; Water, Is at risk for falls; will use the following preventive measure: Bed bolsters to bed...4/12/11 TABS Alarm to w/c for n. [nursing] measure." On 4/14/11 at 9:00 A.M., the compliance nurse provided an "Incident/Accident Report," dated 4/12/11. The report included, "...Noted res on floor...[no] apparent injury, refer to nurses note...Additional comments and/or steps to prevent recurrence: tabs alarm to w/c." 4. On 4/13/11 at 9:10 A.M., during the initial tour, the compliance nurse indicated Resident C had a diagnosis of Alzheimer's Disease,			

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	had a history of falls, and utilized alarms. On 4/13/11 at 11:30 A.M., Resident C was observed sitting in a wheelchair in a lounge, asleep. A self release seatbelt alarm was observed on the resident. No staff were observed interacting with the resident. The clinical record of Resident C was reviewed on 4/13/11 at 11:45 A.M. Diagnoses included, but were not limited to, Alzheimer's Disease and Parkinson's Disease. A Minimum Data Set [MDS] assessment, dated 2/8/11, indicated Resident C had a short-term and long-term memory problem, was moderately impaired in cognitive skills for daily decision-making, required extensive assistance of two+ staff for transfer and bed mobility, and did not ambulate. A test for "Balance during transitions and walking" indicated "Not steady, only able to stabilize with human			

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	assistance" while moving from seated to standing position, moving on and off toilet, and surface-to-surface transfer. The MDS assessment indicated the resident had not fallen since the previous assessment. Nurses Notes included the following notations: 2/15/11 at 5:30 P.M.: "CNA approached Resident room et heard alarm sounding. Resident found in bathroom floor on [left] side...When resident asked what happened she stated 'was going to bathroom.' Resident toileted after writer evaluated." 2/15/11 at 5:45 P.M.: "[Physician] update on incident. Received new orders for UA, C/S [urinalysis, culture and sensitivity]. Also received orders for self releasing seat belt...." A "Falls Care Plan," initially dated 6/10, indicated a problem of			

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	"History of falls...Contributing factors, Alzheimer's Diagnosis, Forgets to ask for assistance...Generalized weakness..." The approaches indicated, "...Encourage to stay seated or wait for assistance before transferring after meals...Is at risk for falls; will use the following preventive measure: Sensor pad to bed/recliner...12/7/10 tabs alarm to w/c, 2/15/11 Self releasing seat belt while in w/c." 5. The closed clinical record of Resident B was reviewed on 4/13/11 at 1:20 P.M. Resident B was admitted to the facility on 3/19/11 with diagnoses including, but not limited to, Aftercare following surgery/digestive system. An admission care plan, undated, indicated: "Falls/Safety Risk/Elopement Risk. Goal: Resident will remain free of injuries and falls. Keep call bell in reach. Enc. use of call light. Instruct resident on safety			

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	Complaint IN00088724. 3.1-35(a) 3.1-35(d)(2)(B)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility	F0282	Iti is tihe practice ofi Pine Haven Healtih and Rehabilitiation Centier tio	05/14/2011

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	failed to ensure a bed alarm ordered for fall prevention was turned on [Resident A], for 1 of 3 residents reviewed for falls, in a sample of 6. Findings include: 1. On 4/14/11 at 9:30 A.M., the facility compliance nurse provided the current facility policy on "Falls Prevention," dated 9/08. The policy included: "...To ensure that residents are safe and that appropriate preventive measures are initiated to minimize injuries related to falls... Fall Preventive Measures...Motion Alarms (Bed/Chair)...Motion Sensors, Smart Floor Mat Alarm...." 2. On 4/13/11 at 9:10 A.M., during the initial tour, Unit Manager # 1 indicated Resident A had fallen the previous night, and was not interviewable. Unit Manager # 1 indicated Resident A required a sensor pad alarm to her wheelchair and bed. Unit Manager # 1 indicated a tabs alarm was added to		**assure tihati tihe residentis' care plans are fiollowed appropriatiely in accordance witih tihe assessed needs.** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** Residentt#A is now receiving services in accordance witth tthe plan ofl care ***Other residents that have the potental to be afiected have been identfied by :*** All residentts have been reviewed tto assure tthatt tthey are receiving services in accordance witth tthe plan ofl care The CNA assignmentt sheetts appropriattely address residentts needs based on tthe assessmentt and a monittoring systtem has been implementted tto assure tthatt intterventtons are appropriattely in place. ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** The intterdisciplinary tteam will be reviewing every flall tto assure tthatt appropriatte intterventtons are in place based on tthe possible cause ofl tthe flall The plan ofl care and tthe CNA assignmentt sheetts will be updatted as needed The nursing sttafl has been in-serviced relatted tto providing services tto our residentts in correlatton witth tthe written plan ofl care. There will be routtne monittoring via rounds tto assure tthatt alarms are in place and fluncttonal in	

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	the wheelchair following the fall the previous night. At that time, Resident A was observed lying in bed. A request was made to determine if the resident's bed sensor alarm was functioning. Unit Manager # 1 checked the alarm, and indicated the alarm was not turned on. Unit Manager # 1 turned the alarm on, and instructed the resident to "Promise you won't get up without asking for help." Unit Manager # 1 indicated she did not know why the alarm was not turned on. The clinical record of Resident A was reviewed on 4/13/11 at 10:40 A.M. Physician's orders, initial date unknown and on the current April 2011 orders, indicated, "Sensor pad alarm to w/c [wheelchair] d/t [due to] decreased safety awareness" and "Sensor pad alarm to bed d/t decreased safety awareness." This federal tag relates to		accordance witth tthe residentts' plan ofl care ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** A Perflormance Improvementt Tool has been inittatted tthatt will be uttlized tto randomly review 5 residentts' comprehensive assessmentt in correlatton witth tthe plan ofl care tto assure tthatt tthe perttnentt inflormatton based on tthe assessmentt is accurattely communicatted and being flollowed in accordance witth tthe residentts' identtfled needs. Alarm placementt and fluncttion will be specifically identtfled on tthe monittoring flor.m The Directtor ofl Nursingor designee, will complette tthis ttool weekly 3x monttthly x3, tthen quartterly 3x. Any areas identtfled via tthe auditt will be immediattely correctted The Qualitty Assurance Committee will review tthe ttool att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed ***The date the systemic changes will be completed:*** 5-14-11	

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	Complaint IN00088724. 3.1-35(g)(2)			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a bed alarm ordered for fall prevention was turned on [Resident A]; failed to ensure alarms were not used in place of supervision; and failed to respond to alarms timely, resulting in a fall with a fractured hip [Resident B], for 3 of 3 residents reviewed for falls, in a sample of 6. Residents A, B, and C Findings include: 1. On 4/14/11 at 9:30 A.M., the facility compliance nurse provided the current facility policy on "Falls	F0323	**F323** **Iti is tihe practice ofi Pine Haven Healtih and Rehabilitiation Centier tio assure tihati tihe** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** Residentts#A and #C have been reassessed relatted tto flall risk and have been reviewed by tthe IDT tto assure tthatt appropriatte intterventtons are in place tto assistt witth tthe preventton ofl flalls. The plans ofl care have been updatted as well as tthe CNA assignmentt sheetts ifl applicable. Residentt#B, as identtfled in tthe 2567, no longer resides att tthe flacilitty ***Other residents that have the potental to be afiected have been identfied by :*** All residentts have been assessed relatted tto flall risk. Based on tthe assessmentt, intterventtons have been implementted tto assistt witth tthe	05/14/2011

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	Prevention," dated 9/08. The policy included: "...To ensure that residents are safe and that appropriate preventive measures are initiated to minimize injuries related to falls. Procedure, If a fall occurs, the Falls Checklist will be initiated with all areas completed before the end of the shift the incident occurred...Nursing staff will document on the resident chart a thorough accounting of the incident as outlined in the Falls Checklist. Fall Preventive Measures...Motion Alarms (Bed/Chair)...Motion Sensors, Smart Floor Mat Alarm...Self-Releasing Alarm Belts, Restraints...All preventive measures must correlate with the resident's cognition level." 2. On 4/13/11 at 2:00 P.M., Unit Manager # 1 provided C.N.A. assignment sheets for her unit. The assignment sheets indicated that 23 residents resided on that unit. 17 of those 23 residents had some type of fall prevention alarm, to alert staff		preventton ofl flalls The plans ofl care and tthe CNA assignmentt sheetts have been updatted ifl indicatted ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** The intterdisciplinary tteam is reviewing all flall risk assessmentts tto assure tthatt perttnentt areas on tthe comprehensive assessmentt are identtfled as partt ofl tthe plan ofl care Based on tthe assessment,ttthe plan ofl care is being updatted in additton tto tthe CNA assignmentt sheett ifl indicatted An in-service has been conductted flor tthe nurses tto assure tthatt tthere is a tthorough understtanding relatted tto tthe issues identtfled on tthe assessmentt being addressed on tthe plan ofl care flor tthe residentt All nursing sttafl has been in-serviced relatted tto providing services tto residentts in accordance witth tthe plan ofl careAs partt ofl tthe systtem change tthe Intterdisciplinary tteam will review all flall,assure tthatt an investtgatton was completted,and assure tthatt tthe care plan has been updatted tto reflectt appropriatte intterventtons based on tthe possible cause ofl tthe flall ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** A Perflormance Improvementt Tool	

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	of unassisted rising. On 4/14/11 at 10:00 A.M., during interview with the compliance nurse, she indicated that her responsibility was to validate that "everything regarding a fall was documented properly, including updating the care plan." The compliance nurse indicated there was not "really an investigation on why a fall occurs," and that the usual intervention following a fall would be to add an alarm. 3. The closed clinical record of Resident B was reviewed on 4/13/11 at 1:20 P.M. Resident B was admitted to the facility on 3/19/11 with diagnoses including, but not limited to, Aftercare following surgery/digestive system. An admission care plan, undated, indicated: "Falls/Safety Risk/Elopement Risk. Goal: Resident will remain free of injuries and falls. Keep call bell in reach. Enc. use of call light. Instruct		has been inittatted tthatt will be uttlized tto randomly review 5 residentts tthatt are considered "High Risk ofl Falls" or who have had an acttual flall tto assure tthatt proper preventtve intterventtons are in place and tthatt all flalls are tthoroughly investtgatted flor proper cause tto assure tthatt appropriatte intterventtons have been implementted in accordance witth tthe assessmentt The ttool will also assure tthatt tthe plan ofl care as well as tthe CNA assignmentt sheetts are updatted appropriattely The Directtor ofl Nursing, or designee, will complette tthis ttool weekly x3, montthly x3, tthen quartterly x3. Any areas identtfled via tthe auditt will be immediattely correctted The Qualitty Assurance Committee will review tthe ttool att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed. ***The date the systemic changes will be completed:*** 5-14-11	

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	resident on safety measures...Mobility alarm SPA [sensor pad alarm] bed [and] chair...." Nurses Notes included the following notations: 3/21/11 [untimed]: "Mental status varies over the course of the day. Confused/forgetful. Decreased safety awareness...Up with assist x 1, wheelchair...." 3/23/11 "11p-7A": "...Confused/Forgetful, Decreased safety awareness...Up with assist...." 3/24/11 at 11:00 A.M.: "...Confused/Forgetful, Decreased safety awareness...Up with assist [of two]...Bathroom with assist...." 3/25/11 at 3:00 A.M.: "Res remains delusional @ this time D/T [due to] res thinks her family is here et this us a hotel...thinks that nephew was in the bed next to her...."			

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3/25/11 at 11:00 A.M.: "Alert [with] some confusion...needs extensive assist [with] ADL's [activities of daily living]...."

3/25/11 at 3:30 P.M.: "Res spa [sensor pad alarm] heard sounding, CNA went to resident's room, resident found lying on back on floor in front of closet. Denies pain, bruise noted to lateral left forehead...assisted to w/c [with] assist x 3...."

3/25/11 at 3:45 P.M.: "Prevantive [sic] to prevent recurrent fall - self-release seat belt...."

The resident was transferred to the hospital on 3/25/11 at 4:45 P.M. A hospital discharge summary indicated, "...The patient was admitted...initially because of weakness and falling down which they thought she just had a urinary tract infection. However, the patient was not able to walk and was hurting on her left side. It was

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	found out the patient had a left femoral neck fracture...." On 4/13/11 at 2:15 P.M., during interview with the compliance nurse, she indicated she would not have considered Resident B interviewable. She indicated Resident B had attempted unassisted ambulation earlier on 3/25/11, "probably around 2:00 P.M.," and a sensor alarm was placed on the resident's bed and wheelchair. The compliance nurse indicated she did not know why documentation regarding the attempt at unassisted ambulation was not in the clinical record. The compliance nurse indicated she was not present when the resident fell, but thought the staff heard the alarm, and found her on the floor in her room. The compliance nurse indicated she had a "falls checklist" that she completes after a fall, to ensure staff called the family and physician and updated the care plan and assignment sheets. The compliance nurse indicated she did			

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	not know if the resident had transferred herself. 4. On 4/13/11 at 9:10 A.M., during the initial tour, Unit Manager # 1 indicated Resident A had fallen the previous night, and was not interviewable. Unit Manager # 1 indicated Resident A required a sensor pad alarm to her wheelchair and bed. Unit Manager # 1 indicated a tabs alarm was added to the wheelchair following the fall the previous night. At that time, Resident A was observed lying in bed. A request was made to determine if the resident's bed sensor alarm was functioning. Unit Manager # 1 checked the alarm, and indicated the alarm was not turned on. Unit Manager # 1 turned the alarm on, and instructed the resident to "Promise you won't get up without asking for help." Unit Manager # 1 indicated she did not know why the alarm was not turned on. The clinical record of Resident A			

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	was reviewed on 4/13/11 at 10:40 A.M. Diagnoses included, but were not limited to, Dementia. A Minimum Data Set [MDS] assessment, dated 1/17/11, indicated the resident scored a 9 out of 15 on a cognitive assessment, required limited assistance of 1 staff for transfer and ambulation, and had not fallen since the previous assessment. A test for "Balance during transitions and walking" indicated "Not steady, only able to stabilize with human assistance" while moving from seated to standing position, walking, and surface-to-surface transfer. A "Fall Risk" assessment, dated 1/19/11, indicated Resident A had intermittent confusion, had 1-2 falls in the previous 3 months, had a balance problem while standing, required the use of an assistive device, and had a total score of 12. The assessment indicated, "Total score of 10 or above represents			

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	HIGH RISK" for falls. Physician's orders, initial date unknown and on the current April 2011 orders, indicated, "Sensor pad alarm to w/c [wheelchair] d/t [due to] decreased safety awareness" and "Sensor pad alarm to bed d/t decreased safety awareness." Nurse's Notes included the following notations: 4/12/11 at 10:00 P.M.: "Staff reports res [resident] yelling out 'nurse.' Upon entering res bathroom noted resident sitting on bottom of floor. W/C breaks [sic] locked. Res assessed for injury, none apparent...Res assisted off floor [with] extensive assist x [two] staff [and] gait belt...Res. placed to bed, alarms on et [and] functioning, call light within reach. TABS alarm added to res. w/c for preventative nursing measure related to decreased safety awareness." 4/13/11 at 1:00 A.M.: "Resident			

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	[up] getting in chair. Resident shut off bed alarm [before] getting out of bed. Instructed resident to leave alarms alone et call for help before getting up." A "Falls Care Plan," initially dated 10/31/10, indicated a problem of "History of falls...Contributing factors, Dementia, Arthritis...Use of w/c...Refusal of assistance, Refusal to use assistive devices." The approaches indicated, "Encourage to stay seated or wait for assistance before transferring after meals. Ensure frequently used items are within reach: Call system; Light cord; Water, Is at risk for falls; will use the following preventive measure: Bed bolsters to bed...4/12/11 TABS Alarm to w/c for n. [nursing] measure." On 4/14/11 at 9:00 A.M., the compliance nurse provided an "Incident/Accident Report," dated 4/12/11. The report included, "...Noted res on floor...[no] apparent injury, refer to nurses			

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	note...Additional comments and/or steps to prevent recurrence: tabs alarm to w/c." Documentation regarding a sensor alarm sounding or functioning was lacking. The compliance nurse indicated at that time that she was unaware if the prescribed sensor alarm sounded or not. 5. On 4/13/11 at 9:10 A.M., during the initial tour, the compliance nurse indicated Resident C had a diagnosis of Alzheimer's Disease, had a history of several falls, and utilized alarms. On 4/13/11 at 11:30 A.M., Resident C was observed sitting in a wheelchair in a lounge, asleep. A self release seatbelt alarm was observed on the resident. No staff were observed interacting with the resident. The clinical record of Resident C was reviewed on 4/13/11 at 11:45 A.M. Diagnoses included, but were not limited to, Alzheimer's Disease			

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	and Parkinson's Disease. A Minimum Data Set [MDS] assessment, dated 2/8/11, indicated Resident C had a short-term and long-term memory problem, was moderately impaired in cognitive skills for daily decision-making, required extensive assistance of two+ staff for transfer and bed mobility, and did not ambulate. A test for "Balance during transitions and walking" indicated "Not steady, only able to stabilize with human assistance" while moving from seated to standing position, moving on and off toilet, and surface-to-surface transfer. The MDS assessment indicated the resident had not fallen since the previous assessment. Nurses Notes included the following notations: 2/15/11 at 5:30 P.M.: "CNA approached Resident room et heard alarm sounding. Resident found in bathroom floor on [left]			

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	side...When resident asked what happened she stated 'was going to bathroom.' Resident toileted after writer evaluated." 2/15/11 at 5:45 P.M.: "[Physician] update on incident. Received new orders for UA, C/S [urinalysis, culture and sensitivity]. Also received orders for self releasing seat belt...." A "Falls Care Plan," initially dated 6/10, indicated a problem of "History of falls...Contributing factors, Alzheimer's Diagnosis, Forgets to ask for assistance...Generalized weakness..." The approaches indicated, "...Encourage to stay seated or wait for assistance before transferring after meals...Is at risk for falls; will use the following preventive measure: Sensor pad to bed/recliner...12/7/10 tabs alarm to w/c, 2/15/11 Self releasing seat belt while in w/c." On 4/14/11 at 10:00 A.M., during			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN HEALTH AND REHABILITATION CENTER	3400 STOCKER DR EVANSVILLE, IN47720

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	interview with the compliance nurse, she indicated, "When [Resident C] was down the hall, we would hear the alarms, and by the time we would get there, she would be on the floor. So we moved her closer to the nursing station." The compliance nurse indicated the resident had experienced several falls. The compliance nurse indicated there was not a process in place to determine the cause of the falls. This federal tag relates to Complaint IN00088724. 3.1-45(a)(2)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure documentation was complete regarding a fall investigation and whether an alarm was functioning [Resident A]; and documentation was complete in regards to a resident's attempt at unassisted ambulation and the addition of sensor alarms [Resident B], for 2 of 3 residents reviewed for falls, in a sample of 6.	F0514	**Iti is tihe practice ofi tihis fiacilitiy tio assure tihati tihe residentis' clinical records are completied appropriatiely in accordance witih tihe regulatiory guidelines** ***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** Residentt#A has been reviewed tto assure all appropriatte intterventtons are in place relatted tto flall preventton. Ifl tthe residentt were tto experience an adittonal incidentt, an investtgatton will be conductted tto attemptt tto dettermine tthe cause ofl tthe flall so tthatt appropriatte	05/14/2011

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	Findings include: 1. On 4/14/11 at 9:30 A.M., the facility compliance nurse provided the current facility policy on "Falls Prevention," dated 9/08. The policy included: "...To ensure that residents are safe and that appropriate preventive measures are initiated to minimize injuries related to falls. ...Nursing staff will document on the resident chart a thorough accounting of the incident as outlined in the Falls Checklist. Fall Preventive Measures...All preventive measures must be added to the Falls Care Plan and dated...Preventive measures must be charted in the nurses notes...." 2. On 4/13/11 at 9:10 A.M., during the initial tour, Unit Manager # 1 indicated Resident A had fallen the previous night, and was not interviewable. Unit Manager # 1 indicated Resident A required a sensor pad alarm to her wheelchair and bed. Unit Manager # 1		intterventtons can be updatted Residentt#B no longer resides in tthe flacilitty ***Other residents that have the potental to be afiected have been identfied by :*** All residentts have been reviewed tto assure tthatt clinical documenttatton is appropriatte ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** The intterdisciplinary tteam is reviewing all flall risk assessmentts tto assure tthatt perttnentt areas on tthe comprehensive assessmentt are identtfled as partt ofl tthe plan ofl care As partt ofl tthe review documenttatton relatted tto an incidentt will also be reviewed tto assure tthatt itt is inclusive ofl perttnentt inflormatton An in-service has been conductted flor tthe nurses tto assure tthatt tthere is a tthorough understtanding relatted tto tthe appropriatte clinical documenttatton necessary including whetther alarms were sounding appropriattely ifl tthe residentt flalls and tthe importtance ofl identtflying ifl residentts are attemptting tto rise unassistted during tthe course ofl tthe day ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** A Perflormance Improvementt Tool	

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	indicated a tabs alarm was added to the wheelchair following the fall the previous night. The clinical record of Resident A was reviewed on 4/13/11 at 10:40 A.M. Diagnoses included, but were not limited to, Dementia. Physician's orders, initial date unknown and on the current April 2011 orders, indicated, "Sensor pad alarm to w/c [wheelchair] d/t [due to] decreased safety awareness" and "Sensor pad alarm to bed d/t decreased safety awareness." Nurse's Notes included the following notations: 4/12/11 at 10:00 P.M.: "Staff reports res [resident] yelling out 'nurse.' Upon entering res bathroom noted resident sitting on bottom of floor. W/C breaks [sic] locked. Res assessed for injury, none apparent...Res assisted off floor [with] extensive assist x [two] staff [and] gait belt...Res. placed to bed,		has been inittatted tthatt will be uttlized tto randomly review5 residentts medical records tto assure tthatt tthe clinical record accurattely identtfles perttnentt inflormatton relatted tto tthe residentts and incidences ofl flallsThe Directtor ofl Nursing, or designee, will complette tthis ttool weekly x3, montthly x3, tthen quartterly x3. Any areas identtfled via tthe auditt will be immediattely correctted The Qualitty Assurance Committee will review tthe ttool att tthe scheduled meettng flollowing tthe completton ofl tthe ttool witth recommendattons as needed. ***The date the systemic changes will be completed:*** 5-14-11	

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	alarms on et [and] functioning, call light within reach. TABS alarm added to res. w/c for preventative nursing measure related to decreased safety awareness." A "Falls Care Plan," initially dated 10/31/10, indicated a problem of "History of falls...Contributing factors, Dementia, Arthritis...Use of w/c...Refusal of assistance, Refusal to use assistive devices." The approaches indicated, "Encourage to stay seated or wait for assistance before transferring after meals. Ensure frequently used items are within reach: Call system; Light cord; Water, Is at risk for falls; will use the following preventive measure: Bed bolsters to bed...4/12/11 TABS Alarm to w/c for n. [nursing] measure." Documentation regarding the use of sensor pads to the bed and wheelchair was lacking. On 4/14/11 at 9:00 A.M., the compliance nurse provided an "Incident/Accident Report," dated			

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	4/12/11. The report included, "...Noted res on floor...[no] apparent injury, refer to nurses note...Additional comments and/or steps to prevent recurrence: tabs alarm to w/c." Documentation regarding a sensor alarm sounding or functioning was lacking. The compliance nurse indicated at that time that she was unaware if the prescribed sensor alarm sounded or not, and indicated that fact should be in the nurses notes. 3. The closed clinical record of Resident B was reviewed on 4/13/11 at 1:20 P.M. Resident B was admitted to the facility on 3/19/11 with diagnoses including, but not limited to, Aftercare following surgery/digestive system. An admission care plan, undated, indicated: "Falls/Safety Risk/Elopement Risk. Goal: Resident will remain free of injuries and falls. Keep call bell in reach. Enc. use of call light. Instruct resident on safety			

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	measures...Mobility alarm SPA [sensor pad alarm] bed [and] chair...." Nurses Notes included the following notations: 3/25/11 at 3:00 A.M.: "Res remains delusional @ this time D/T [due to] res thinks her family is here et this us a hotel...thinks that nephew was in the bed next to her...." 3/25/11 at 11:00 A.M.: "Alert [with] some confusion...needs extensive assist [with] ADL's [activities of daily living]...." 3/25/11 at 3:30 P.M.: "Res spa [sensor pad alarm] heard sounding, CNA went to resident's room, resident found lying on back on floor in front of closet. Denies pain, bruise noted to lateral left forehead...assisted to w/c [with] assist x 3...." On 4/13/11 at 2:15 P.M., during interview with the compliance			

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	nurse, she indicated she would not have considered Resident B interviewable. She indicated Resident B had attempted unassisted ambulation earlier on 3/25/11, "probably around 2:00 P.M.," and a sensor alarm was placed on the resident's bed and wheelchair. The compliance nurse indicated she did not know why documentation regarding the attempt at unassisted ambulation was not in the clinical record. This federal tag relates to Complaint IN00088724. 3.1-50(a)(1)			

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